Making New Jersey a Model for Patient Safety

The Massachusetts Experience

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New Jersey PRIORITIES…

- What is the **purpose** of the reporting system? What role does the reporting system play in the state's efforts to improve patient safety?
- How can the state **create an environment** that encourages reporting? Are there incentives to report? Is there buy-in from providers?
- What are the **lessons learned** -- what works or doesn't work?

DPH MISSION STATEMENT

- We believe in the ***power of prevention***.
- We work to help all people reach their ***full potential*** for health.
- We ensure that the people of the Commonwealth receive ***quality health care*** and live in a safe and healthy environment.
- We ***build partnerships*** to maximize access to affordable, high quality health care.
- We are especially dedicated to the health concerns of ***those most in need.***
- We ***empower*** our communities to help themselves.
- We ***protect, preserve, and improve*** the health of all the Commonwealth's residents.

Bureau Of Health Quality Management

- **Division of Health Care Quality**
- **Office of Patient Protection**
- **Division of Food and Drugs**
- **Radiation Control Program**
- **Office of Emergency Medical Services**
- **Community Sanitation**
- **Effective 1/1/03, Boards of Medicine, Nursing, Pharmacy, Dentistry, Physician Assistants, Respiratory Care, Perfusionists, Nursing Home Administrators**

Public Health Paradigms

TRADITIONAL

- Prevention
- Promotion
- Protection

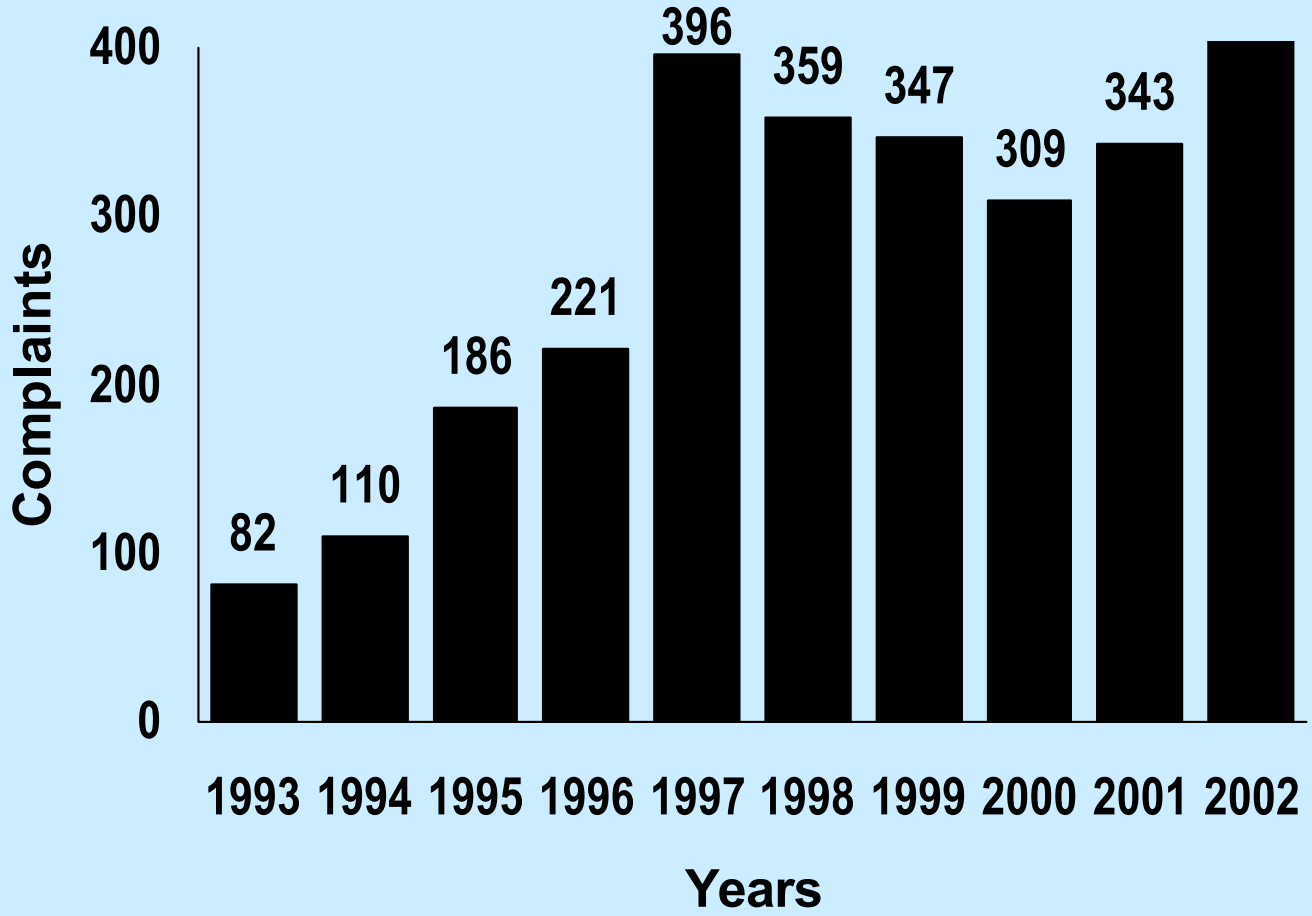
NEW APPROACHES

- Synergy
- Cloning
- Proactive vs Reactive

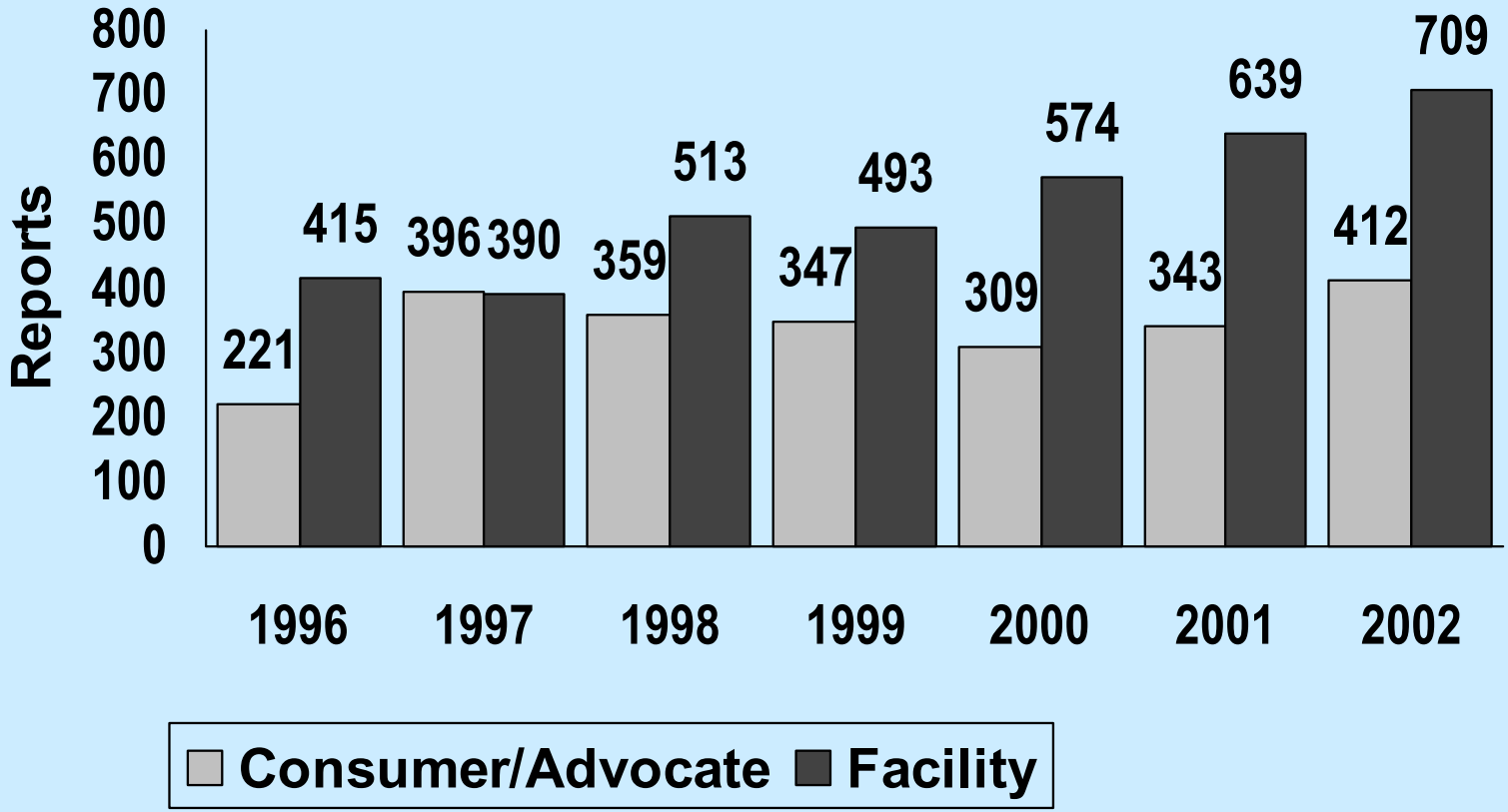
Total Complaint and Facility Incident Reports Received by DPH

Facility Type	1996	1997	1998	1999	2000	2001	2002	%Change 1996 2002
LTC	10,288	12,103	12,238	12,777	12,983	12,306	11,770	+14%
Hospital	636	786	872	840	883	982	1,121	+76%
Clinic	55	80	57	61	51	40	53	-4%
HHA	114	55	140	66	79	116	101	-11%
Other	37	39	19	17	44	35	58	+64%
Totals	11,130	13,063	13,326	13,761	14,040	13,479	13,103	+18%

Hospital Consumer/Advocate Complaints Calendar Years 1993 - 2001



Hospital Complaints and Incidents Received by Reporter Type Calendar Years 1996 to 2001



Division of Health Care Quality

- Hospitals, nursing homes, rest homes, clinics, home health agencies, clinical laboratories, blood banks, dialysis centers, hospices, rehab services, state schools
- As of 10/7/02 - ambulance and EMT investigations
- Patient Abuse Statute MGL Ch.111, S72F-L Determination of Need Programs
    - Essential services - closures, cardiac surgery (new laws)
    - Organ Transplant Services

HCQ Primary Functions

- **Licensure and Certification Surveys**

- **Intake Reports**
  - **Complaints**
  - **Serious Incidents**
  - **Abuse, Neglect, Mistreatment, Misappropriation**

- **Investigations**

Intake Reports

- Facility Reports of Serious Incidents
  - Licensure regulations -
    - LTCF 105 CMR 150.002(G)(1),(2) and (3)
    - Hospitals 105 CMR 130.331
    - Clinics 105 CMR 140.307
  - Patient abuse statute - LTCF, home health, hospice and homemaker agencies 105 CMR 155.000
- Consumer/Advocate Complaints
  - Patient abuse & complaint hotline

WHAT IS REPORTABLE?

HOSPITALS

- **Fire, Suicide, Strikes**
- **Serious physical injuries requiring significant additional diagnostic or treatment measures**
- **Other serious incidents that affect health and safety of patients….. not anticipated in the course of normal events**

NURSING HOMES

- Abuse
- Neglect
- Mistreatment
- Misappropriation
- Serious Incidents affecting health and safety of patients

REPORTING & INVESTIGATION SYSTEMS

HOSPITALS

- Most serious: immediate reporting by telephone
- Others: 7 days in writing
- Not all require investigation
- Reports are public after investigation complete

NURSING HOMES

- Immediate/7days written
- Abuse - must be investigated within 7 days
- Abuse Reports confidential (some exceptions)

Types of Reports

- Abuse
- Neglect
- Misappropriation
- Injuries
- Quality of Care
- Patient Rights
- Quality of Life
- Life Safety
- Regulatory Violations
- Unusual Occurrences
- Unanticipated Deaths
- Lack of Services
- Criminal Acts

Processing Reports

- **Reviewed by SW and RN surveyors**
- **Disposition**
- **Prioritize Complaints/Reports**
  - **Abuse, Neglect, Misappropriation**
  - **Timing/on-going concern or threat**
  - **Severity of harm**
  - **Source of complaint/report**
  - **Consumer, advocate, agency referral, or facility**

Types of Dispositions

- **Review and keep on file (used for pre-survey prep)**
- **Off site investigation**
- **Defer to next on-site visit**
- **On-site investigation**
- **Refer to another agency**
  - **Elder Affairs, Attorney General's Office**
  - **Professional Boards**
  - **State agencies - DMH, DMR, etc.**
  - **CMS - medicare fraud**

Difficulties Encountered

- **Insufficient information**
  - no date, patient, identified facility
  - vague or general concerns
  - Incomplete reports
  - Illegible reports
- **Duplicate reporting**
- **Under or over reporting**
  - Poor understanding of reporting requirements
- **Difficulties in accessing Medical Examiner's reports**

Needs…

- Culture of Fear ⇒ Culture of Safety
- Culture of Denial ⇒ Culture of Learning

Mass Coalition History

- Formed in 1997 -
- First in the nation:

  statewide public-private partnership to improve patient safety and to prevent medical errors

Medical Error Coalition: A Look Back….

- 3/95 Dana Farber incident
- 5/95 DPH Circular Letter
- 9/95 MHA Briefing
- 1/96 MHA Medication Project
- 10/96 Annenberg I
- 1/97 First Coalition Planning Meeting
- 7/98 Officially launched statewide Coalition
- 4/01 Hired Executive Director
- 7/02 Incorporation as a non-profit organization

Historical Barriers And Issues

- Fear
- Trust
- Increased Public Awareness
- Confidentiality
- Ownership
- Multiple Oversight Agencies/Reporting Systems
- Media Frenzy
- Lack of a Forum

Members

- **State and federal licensure/oversight agencies**
- **Professional associations for hospitals, physicians, nurses, nurse-executives and long-term care organizations**
- **Accreditation organizations**
- **Individual health care providers**
- **Professional liability insurance organizations**
- **Clinical researchers**
- **Consumer organizations**
- **State legislator**
- **Purchasers/health plans**

Mission

- Identify and implement best practices to minimize medical errors
- Increase awareness of error prevention strategies through public and professional education
- Minimize duplication of regulatory and JCAHO requirements

Medical Error Coalition: Media Results

- Coalition recognized by trade press and statewide media
- Example: Boston Globe
  - major series on medical errors
  - provided background on complexities of issue and work of Coalition & hospitals
  - positive follow-up editorials

The Boston Globe

BENJAMIN B. TAYLOR, *Publisher & Chairman*
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Founded 1872

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Preventing hospital mistakes

It's an enticing theory: Hospital errors should be treated not as negligent actions but as a problem of the medical care system that needs to be addressed preventively. Will the theory work in practice at Massachusetts hospitals? That will depend on follow-up and rigorous

tasks

Errors, launched two years ago, represents a commitment by hospitals, medical professionals, and public health officials to get to the root cause of errors and to improve medical systems so mistakes are prevented.

This approach has improved the safety of air travel and nuclear power plants, but hospital care is less straightforward. Physicians and nurses have to make decisions

overdose at the Dana-Farber Cancer Institute in Boston. This prestigious institution learned from the error, and its systems of care are now top-notch. The great challenge for Dana-Farber is to maintain these standards and for the coalition to make sure that similar improvements prevent future tragedies.

"…The Coalition for the Prevention of Medical Errors…represents a commitment by hospitals, medical professionals, and public health officials to get at the root cause of errors and to improve medical systems so mistakes are prevented."

Medical Error Coalition: Lessons Learned

- Maintain unity by emphasizing shared goal of patient safety
- Communication, communication, communication...
- Secure support at leadership level
- Involve clinicians throughout the process
- Learn from others already active in the field
- Strike a balance: quick solutions vs. broad buy-in
- Engage the media, but don’t let them drive the process
- Recognize everyone has a seat at the table

Priorities…

- Mass Coalition for Prevention of Medical Errors
  - Best Practice Initiatives
  - Lessons Learned
- Focus on Prevention Strategies
- Increase Public Participation
- Improve Education and Training

Activities

- Convening
- Education
- Regulatory reform/coordination

Activities

- **Reducing Medication Error : Inpatient**
  - Inventory current practices (MHA)
  - Consensus document of best practices
  - Disseminated: Educational sessions& website
  - Safety First Alerts
  - Consumer brochure
  - Survey of implementation (MHA)

Activities

- **Reducing Medication Error: Ambulatory**
  - Consensus group to identify best practices for prescribing, monitoring, dispensing, and communication
  - Dissemination and education
  - Assess impact

Activities

- **Reducing Restraints/Seclusion**: in med/surg; ED, psychiatric services and LTC
  - Consensus document of best practices
  - Educational program and resources materials with strategies and tools
  - Consumer education materials
  - Listserv
  - Assess impact

Activities

- **Regulatory Workgroup: Reducing duplication and supporting a culture of safety**
  - Develop inventory of current hospital reporting requirements
  - Identify opportunities for streamlining/reducing duplication and creating a culture of safety
- **Shared Accountability Project**
  - Develop shared vision of responsibilities of clinicians, organizations, and regulators and activities of each to support a culture of safety

Other Educational Activities

- Improvement strategies for clinical teams
  - ICU care
  - Medication administration; including CPOE
  - Cardiac surgery outcomes
- Other educational programs
  - Disclosure
  - Principles and strategies

Marketing and Communication

- Outreach to media with education about patient safety and the Coalition
  - Systems analysis and improvement
  - Culture of safety
  - Activities of the Coalition
- Website with information and tools
  - http://www.mhalink.org/mcpme/mcpme_publications.htm
- Visibility in patient safety/health care coverage

Betsy Lehman Center

- Best practices
- Causes of error and prevention strategies
- Public and professional education
- Coordinate state programs for patient safety
- Information collected is confidential
- Annual reports to legislature
- Established without funding
- Coalition as Advisory Committee

Massachusetts AHRQ Grant

- **Aim 1: Evaluation and Improvement of MARS**
  - **Evaluation of reporting system, definitions of reportable events, comparisons with other systems, literature**
  - **Enhance the coding scheme to assure that it optimally captures relevant data**
  - **Improve reporting methods and feedback systems**

Massachusetts AHRQ Grant

- **Aim 2: Development and Implementation of Best Practices to Reduce Errors in Hospitals:**
  - **Identify two priority topics**
  - **Convene consensus groups and develop best practices**
  - **Dissemination and supporting implementation**
  - **Assess impact in third year**

Aim 2: Coalition Best Practice Topics

- **Reconciling Medications:**

  Systematic approach to reduce medication errors at admission, transfers within the hospital, and discharge

- **Communicating Critical Test Results:**

  Ensuring timely and reliable communication of critical test results to clinician responsible to take action

Massachusetts AHRQ Grant

- **Aim 3: What do Public Reporting Systems Accomplish: The Hospital View**

  Surveys of Hospital Execs, Risk Managers , Legal Staff to determine:

  1. **Strengths and Weaknesses of the MARS system**
  2. **Patient Disclosure Policies - what are they and what is impact mandatory reporting?**

Massachusetts AHRQ Grant

- **Aim 4: What Patients Want to Know: Survey Recently Hospitalized Patients to Determine:**
  - **Patient perceptions about the rate of sub optimal care or error**
  - **Patient satisfaction with the way information was disclosed**
  - **The ability of patients to accurately report the occurrence of adverse events using chart reviews as a gold standard**